State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION
455 Golden Gate Avenue, 9th Floor
San Francisco, CA 94102

NOTICE OF EMERGENCY REGULATORY ADOPTION

Finding of Emergency and Informative Digest

Subject Matter of Regulations: Workers' Compensation – Independent Medical Review

The Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her by Labor Code sections 59, 133, 4616 and 4616.4, proposes to adopt Title 8, California Code of Regulations, sections 9768.1 through 9768.17. This action is necessary in order to implement, on an emergency basis, the provisions of Labor Code section 4616.4, as implemented by Senate Bill 899 (Chapter 34, stats. of 2004, effective April 19, 2004). The regulations are mandated by Labor Code section 4616(g), which provides that on or before November 1, 2004 the Administrative Director "shall adopt regulations implementing this article" so that "on or after January 1, 2005, an insurer or employer may establish or modify a medical provide network." The regulations that provide for the establishment of a medical provider network, sections 9767.1 through 9767.14, were effective as of November 1, 2004. These Independent Medical Review regulations set forth the procedures for a physician to contract to be an independent medical reviewer ("IMR"), set forth the procedure for an injured worker to request an independent medical review, and set forth the duties of the IMR should an injured employee dispute the third physician's opinion obtained within the medical provider network. Because medical provide networks may be established as of January 1, 2005, it is necessary for these Independent Medical Review regulations to be effective no later than January 1, 2005.

Finding of Emergency

The Administrative Director of the Division of Workers' Compensation finds that the proposed regulations attached hereto are necessary for the immediate preservation of the public peace, health and safety or general welfare.

Statement of Emergency

The containment of medical costs in the workers' compensation system is critical for the future of California. The total annual costs of the California workers' compensation system more than doubled from 1995 to 2002, growing from about $9.5 billion to about $25 billion. During the same time, workers' compensation medical expenditures increased from $2.6 billion to $5.3 billion per year. It is estimated that in 2004, medical payments will account for two-thirds of all workers' compensation costs. (Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Care in California: Costs, Fact Sheet Number 2, August 2003, http://www.dir.ca.gov/chswc/WC_factSheets/WorkersCompFSCost.pdf.)

The rise in medical care expenditures has adversely affected the entire workers' compensation system. Employers in California experience higher costs for workers' compensation medical care than employers in most other states. California ranks highest in workers' compensation premiums. Studies indicate that the high utilization of specific kinds of medical services in California workers' compensation system is one of the major reasons for the difference. Pursuant to the Workers' Compensation Research Institute, the median number of medical visits per workers' compensation claim in California is more than 70 percent greater than other states. The higher utilization is mostly due to higher rates of specific kinds of services including, physical medicine, psychological therapy, and chiropractic care. Further, the evidence for higher medical costs in workers' compensation relative to group health is consistently strong. Studies indicate a substantial positive differential for workers' compensation medical care. The studies find that workers' compensation pays 33%-300% more than group health to treat the same conditions. (Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Care in California: Costs, Fact Sheet Number 2, August 2003, http://www.dir.ca.gov/chswc/WC_factSheets/WorkersCompFSCost.pdf; Outline: Estimating the Range of Savings from Introduction of Guidelines Including ACOEM (Revised), Frank Neuhauser, UC DATA/Survey Research Center, University of California, Berkeley, October 20, 2003, http://www.dir.ca.gov/chswc/EstimatingRangeSavingsGuidelinesACOEM.doc.)

In response to the State's widely-acknowledged workers' compensation crisis, the Legislature passed Senate Bill 899 (Chapter 34, stats. of 2004, effective April 19, 2004). Senate Bill 899 included several provisions designated to control workers' compensation costs including Labor Code section 4616 et seq. which provides for the implementation of medical provider networks.

Labor Code section 4616 provides that an employer (defined by Labor Code section 4616.5 as a self-insured employer, joint powers authority, or the state) or an insurer may establish or modify a medical provider network for the provisions of medical treatment to injured employees. The medical treatment must be readily available at reasonable times to all employees and all medical treatment must be readily accessible. If the employer or insurer has established a medical provider network and if the employee has not predesignated a physician pursuant to Labor Code section 4600(d), the injured employee will be required to seek his or her medical treatment from a physician within the medical provider network.

Emergency regulations that implement Labor Code section 4616 et seq. by setting forth the requirements to establish a medical provider network became effective on November 1, 2004. As of January 1, 2005, insurers and self-insured employers may establish a medical provider network. However, the medical provider regulations that are now in effect did not include implementation of Labor Code section 4616.4, which requires the Administrative Director to contract with individual physicians or an independent medical review organization to perform independent medical reviews. The statute also requires that the independent medical reviewer be appropriately credentialed; the reviews provided are timely, clear, and credible, and monitored for quality; the method of selecting physicians is fair and impartial; the medical records are confidential; and there is adequate screening for conflicts of interest. For employees receiving medical treatment within a medical provider network, the statute provides that if an injured employee disputes the diagnosis, diagnostic service or medical treatment prescribed by the

treating physician, the employee may seek the opinion of another physician in the medical provider network. If the injured employee disputes the diagnosis, or diagnostic service, or medical treatment prescribed by the second physician, the employee may seek the opinion of a third physician in the medical provider network. If, after the third physician's opinion, the diagnosis, diagnostic service or medical treatment remains disputed, the injured employee may request an independent medical review. After an examination of the injured employee or record review if an examination is not requested by the injured employee, the independent medical reviewer shall issue a report containing his or her analysis and determination whether the disputed health care service was consistent with the appropriate guidelines.

Therefore, it is essential that these Independent Medical Review regulations be effective no later than January 1, 2005, so that the Administrative Director may begin to contract with physicians to perform independent medical reviews which may be requested by injured workers receiving treatment within medical provider networks.

This mandatory independent medical review component of the medical provider network program, which is intended to generate substantial savings, will not be effective without regulatory interpretation. Further, lack of regulations setting forth the requirements to serve as an IMR and the procedure for requesting an independent medical review will result in confusion over the legal requirements, likely resulting in increased litigation and costs. The regulations define the terms used in the controlling statutes, set forth the requirements to serve as an IMR, clarify the contract application procedure, provide the required forms for the IMR contract application and the injured employee's application to request IMR, clarify the procedure to request an IMR, and clarify the procedures for an in-person examination. Labor Code section 4616 requires the Administrative Director to adopt regulations that implement the medical provider networks article, which includes the independent medical review process. The adoption of these regulations will ensure that insurers and employers will be able to manage medical provider networks that will reduce medical costs and provide quality medical care to injured employees.

The Administrative Director has therefore determined that the emergency adoption of the proposed regulations is necessary for the immediate preservation of the public peace, health and safety or general welfare.

Authority and Reference

The Administrative Director is undertaking this regulatory action pursuant to the authority vested in her by Labor Code sections 59, 133, 4616 and 4616.4.

Reference is to Labor Code sections 4616.3, 4616.4; and 5307.27; Government Code sections 11400.20, 11415.10 and 11522.

Informative Digest

These regulations are required by a legislative enactment - Senate Bill 899 (Chapter 34, stats. of

2004, effective April 19, 2004). Senate Bill 899 included Labor Code sections 4616 though 4616.7, which provide for the establishment of medical provider networks. Labor Code section 4616.4 specifically authorizes the Administrative Director to contract with an independent medical review organization or individual physicians to perform independent medical reviews.

Labor Code section 4616 provides that on or after January 1, 2005, an insurer or employer may establish or modify a medical provider network for the provision of medical treatment to injured employees. Labor Code section 4616(g) provides that on or before November 1, 2004, the Administrative Director, in consultation with the Department of Managed Health Care, shall adopt regulations implementing this article. The Administrative Director shall develop regulations that establish procedures for purposes of making medical provider network modifications.

Labor Code section 4616.3 provides that when the injured employee notifies the employer of the injury or files a claim for workers' compensation with the employer, the employer shall arrange an initial medical evaluation and begin treatment. The employer shall notify the employee of his or her right to be treated by a physician of his or her choice after the first visit from within the medical provider network, and the method by which the list of participating providers may be accessed by the employee. This section also provides that if an injured employee disputes the diagnosis, diagnostic service or medical treatment prescribed by the treating physician, the employee may seek the opinion of another physician in the medical provider network. If the injured employee disputes the diagnosis or treatment prescribed by the second physician, the employee may seek the opinion of a third physician in the medical provider network.

Labor Code section 4616.4 authorizes the Administrative Director to contract with individual physicians to act as independent medical reviewers. If, after the third physician's opinion, the diagnosis, diagnostic service or medical treatment remains disputed, the injured employee may request an independent medical review.

Pursuant to the requirement of Labor Code section 4616(g), the Administrative Director has consulted with the Department of Managed Health Care regarding these proposed regulations.

The Administrative Director now adopts administrative regulations governing the independent medical review process. These regulations implement, interpret, and make specific section 4616.4 of the Labor Code as follows:

1. Section 9768.1 Definitions.

This section provides definitions for the following key terms: "American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines," "Appropriate specialty," "In-person examination," "Independent medical reviewer," "Material familial affiliation," "Material financial affiliation," "Material professional affiliation," "Medical emergency," "Medical Provider Network Contact," and "Residence." The definitions are provided to ensure that their meaning, as used in the regulations, will be clear to the regulated public.

2. Section 9768.2 Conflicts of Interest

This section sets forth the prohibited conflicts of interest for an independent medical reviewer. Specifically, the IMR shall not have any material, professional, familial, or financial affiliation with any of the following: (1) the injured employee's employer or employer's workers' compensation insurer; (2) any officer, director, management employee, or attorney of the injured employee's medical provider network, employer or employer's workers' compensation insurer; (3) any treating health care provider proposing the service or treatment; (4) the institution at which the service or treatment would be provided, if known; (5) the development or manufacture of the principal drug, device, procedure, or other therapy proposed for the injured employee whose treatment is under review; or (6) the injured employee, the injured employee's immediate family, or the injured employee's attorney. Additionally, the IMR shall not have a contractual agreement to provide physician services for the injured employee's MPN if the IMR is within a 35 mile radius of the treating physician, and the IMR shall not have previously treated or examined the injured employee.

3. Section 9768.3 Qualifications of Independent Medical Reviewers

This section sets forth the required qualifications to be on the Administrative Director's list of independent medical reviewers. The physician must file a Physician Contract Application pursuant to section 9768.5 and demonstrate that (1) the physician is board certified; (2) has an unrestricted license as a physician in California under the appropriate licensing Board; (3) is not currently under accusation for a quality of care violation, fraud related to medical practice or felony conviction or conviction of a crime related to the conduct of his or her practice of medicine by any governmental physician licensing agency; (4) has not been terminated or had discipline imposed by the Industrial Medical Council or Administrative Director in relation to the physician's role as a Qualified Medical Evaluator; is not currently under accusation by the Industrial Medical Council or Administrative Director; has not been denied renewal of Qualified Medical Evaluator status, except for non-completion of continuing education or for non-payment of fees; has neither resigned nor failed to renew Qualified Medical Evaluator status while under accusation or probation by the Industrial Medical Council or Administrative Director or after notification that reappointment as a Qualified Medical Evaluator may or would be denied for reasons other than non-completion of continuing education or non-payment of fees; and has not filed any applications or forms with the Industrial Medical Council or Administrative Director which contained any untrue material statements; (5) has not been convicted of a felony crime or a crime related to the conduct of his or her practice of medicine; and (6) has no history of disciplinary action or sanction, including but not limited to, loss of staff privileges or participation restrictions taken or pending by any hospital, government or regulatory body.

4. Section 9768.4 IMR Contract Application Procedures

This section informs the physician seeking to serve as an independent medical reviewer how to apply to the Administrative Director. In addition to submitting the Physician Contract Application set forth in section 9768.5, the physician must furnish a certified copy of his or her

board certification, a copy of his or her current license to practice medicine, and submit other documentation of his or her qualifications as the Administrative Director may require; designate specialties based on each of his or her board certifications; designate the address(es) of the physician's office with necessary medical equipment where in-person examinations will be held; agree to see any injured worker assigned to him or her within 30 days unless there is a conflict of interest as defined in section 9768.2. The section also requires the physician to keep the Administrative Director informed of any change of address, telephone, email address or fax number, and of any disciplinary action taken by a licensing board.

The section provides that the Administrative Director shall maintain a list of physicians who have applied, and whom the Administrative Director has contracted with to conduct independent medical reviews under Labor Code section 4616.3. The IMR contract term is two years and a physician may apply to serve for subsequent two year terms.

5. Section 9768.5 Physician Contract Application Form

This section provides the mandatory contract application form. In order to be selected to serve as an independent medical reviewer, a physician must complete the contract application, providing the required information regarding his or her qualifications, listing entities with whom a conflict exists, and agreeing to comply with the requirements set forth in these regulations. The contract application is not accepted by the Administrative Director until it is signed by the Administrative Director.

6. Section 9768.6 Administrative Director's Action on Contract Application Submitted by Physician

This section provides that, if after reviewing a completed contract application, the Administrative Director finds that the physician meets the qualifications, the Administrative Director shall accept the physician's contract application to be an independent medical reviewer by executing the contract, notify the physician by mail, and add the physician's name to the list of independent medical reviewers. The contract term shall be for a two-year term beginning with the date of appointment by the Administrative Director.

If the Administrative Director determines that a physician does not meet the qualifications, he/she shall notify the physician by mail that the physician's contract application is not accepted and the reason for the rejection. A physician whose contract application has not been accepted may reapply. If the Administrative Director denies a physician's contract application following at least two subsequent submissions, the physician may seek further review of the Administrative Director's decision by filing an appeal with the Workers' Compensation Appeals Board, and serving a copy on the Administrative Director, within twenty days after receipt of the denial.

7. Section 9768.7 IMR Request to be Placed on Voluntary Inactive Status

This section provides that a physician may request to be placed on the inactive list during the IMR contract term. The physician shall submit the request to the Administrative Director and

specify the time period that he or she is requesting to be on voluntary inactive status. The two-year contract term is not extended due to a physician's request to be on voluntary inactive status.

8. Section 9768.8 Removal of Physicians from Independent Medical Reviewer List

This section provides that the Administrative Director may cancel the IMR contract and remove a physician from the independent medical reviewer list if the Administrative Director determines that: (1) the physician has not served the independent medical review report in a case within the time limits prescribed in the regulations on more than one occasion; or (2) the physician has not met the reporting requirements on more than one occasion; or (3) the physician has at any time failed to disclose to the Administrative Director that the physician had a conflict of interest pursuant to section 9768.2; or (4) the physician has failed to schedule appointments within the time frame required by these regulations on more than one occasion.

Additionally, the Administrative Director shall cancel the IMR contract and remove a physician from the independent medical reviewer list if the Administrative Director determines that: (1) the physician no longer meets the qualifications to be on the list; or (2) the physician's contract application to be on the list contained material statements which were not true.

The section also provides that the Administrative Director shall place a physician on an inactive list up to the end of the two year contract term whenever the Administrative Director determines that the appropriate licensing Board from whom the physician is licensed has filed an accusation for a quality of care violation, fraud related to medical practice, or conviction of a felony crime or crime related to the conduct of his or her practice of medicine against the physician or taken other action restricting the physician's medical license. If the accusation or action is later withdrawn, dismissed or determined to be without merit during the two year contract term, the physician shall advise the Administrative Director who will then remove the physician's name from the inactive list. If the accusation or action is withdrawn, dismissed or determined to be without merit after the expiration of the two year contract term, the physician may re-apply pursuant to section 9768.4.

Upon removal of a physician from the independent medical reviewer list or placement on the inactive list, the Administrative Director shall advise the physician by mail of the removal, the Administrative Director's reasons for such action, and the right to request a hearing on the removal from the IMR list or placement on the inactive list.

A physician who has been mailed a notice of removal from the list or placement on the inactive list, may, within 30 calendar days of the mailing of the notice, request a hearing by filing a written request for hearing with the Administrative Director. If a written request for hearing is not received by the Administrative Director within 30 calendar days of the mailing of the notice, the physician shall be deemed to have waived any appeal or request for hearing.

Upon receipt of a written request for hearing, the Administrative Director shall prepare an accusation and serve the physician with the accusation, as provided in Government Code section 11503. Hearings shall be held under the procedures of Chapter 5 of Part 1 of Division 3 of Title

2 of the Government Code (commencing with section 11500) and the regulations of the Office of Administrative Hearings (Title 1, California Code of Regulations, section 1000 et seq.). Failure to timely file a notice of defense or failure to appear at a noticed hearing or conference shall constitute a waiver of a right to a hearing.

A physician who has been removed from the list may petition for reinstatement after one year has elapsed since the effective date of the Administrative Director's decision on the physician's removal. The provisions of Government Code section 11522 shall apply to such petition.

9. Section 9768.9 Procedure for Requesting an Independent Medical Review

This section provides the procedure for a covered employee to request an independent medical review. At the time of the selection of the physician for a third opinion, the MPN Contact shall notify the covered employee about the independent medical review process and provide the covered employee with an "Application for Independent Medical Review" form set forth in section 9768.10. The MPN Contact shall fill out the "MPN Contact section" of the form and send the form to the covered injured employee.

If a covered employee disputes the diagnostic service, diagnosis or medical treatment prescribed by the third opinion physician, the covered employee may request an Independent Medical Review by filing the completed Application for Independent Medical Review form with the Administrative Director. The covered employee shall complete the "employee section" of the form, indicate on the form whether he or she requests an in-person examination or record review, and may list an alternative specialty, if any, that is different from the specialty of the treating physician.

The Administrative Director shall select an IMR with an appropriate specialty within ten business days of receiving the Application for Independent Medical Review form. The Administrative Director's selection of the IMR shall be based on the specialty of the treating physician, the alternative specialties listed by the covered employee and the MPN Contact, and the information submitted with the Application for Independent Medical Review.

If the covered employee requests an in-person examination, the Administrative Director shall randomly select a physician from the list of available independent medical reviewers, with an appropriate specialty, who has an office located within thirty miles of the employee's residence address, to be the independent medical reviewer. If there is only one physician with an appropriate specialty within thirty miles of the employee's residence address, that physician shall be selected to be the independent medical reviewer. If there are no physicians with an appropriate specialty who have offices located within thirty miles of the employee's residence address, the Administrative Director shall search in increasing five mile increments, until one physician is located. If there are no available physicians with this appropriate specialty, the Administrative Director may choose another specialty based on the information submitted.

If the covered employee requests a record review, then the Administrative Director shall randomly select a physician with an appropriate specialty from the list of available independent

medical reviewers to be the IMR. If there are no physicians with an appropriate specialty, the Administrative Director may choose another specialty based on the information submitted.

The Administrative Director shall send written notification of the name and contact information of the IMR to the covered employee, the employee's attorney, if any, the MPN Contact and the IMR. The Administrative Director shall send a copy of the completed Application for Independent Medical Review to the IMR.

The covered employee, MPN Contact, or the selected IMR can object within ten calendar days from receipt of the name of the IMR to the selection if there is a conflict of interest as defined by section 9768.2. If the IMR determines that he or she does not practice the appropriate specialty, the IMR shall withdraw within 10 calendar days of receipt of the notification of selection. If this conflict is verified or the IMR withdraws, the Administrative Director shall select another IMR from the same specialty. If there are no available physicians with the same specialty, the Administrative Director may select an IMR with another specialty based on the information submitted.

If the covered employee requests an in-person exam, within 60 calendar days of receiving the name of the IMR, the covered employee shall contact the IMR to arrange an appointment. If the covered employee fails to contact the IMR for an appointment within 60 calendar days of receiving the name of the IMR, then the employee shall be deemed to have waived the IMR process with regard to this disputed diagnosis or treatment of this treating physician. The IMR shall schedule an appointment with the covered employee within 30 calendar days of the request for an appointment, unless all parties agree to a later date. The IMR shall notify the MPN Contact of the appointment date.

The covered employee shall provide written notice to the Administrative Director and the MPN Contact if the covered employee decides to withdraw the request for an independent medical review.

During this process, the employee is required to continue his or her treatment with the treating physician or a physician of his or her choice within the MPN pursuant to section 9767.6.

10. Section 9768.10 Application for Independent Medical Review (Form)

This is the mandatory Application for an Independent Medical Review form that must be filled out by the injured employee and MPN Contact. The form must be sent to the Administrative Director. The form instructions are on the reverse side of the form.

11. Section 9768.11 In-Person Examination or Record Review IMR Procedure

This section sets forth the procedure for an in-person IMR examination and IMR record review. The MPN Contact shall send all relevant medical records, including x-ray, MRI, CT, and other diagnostic studies, the treating physician's report, with the disputed treatment or diagnosis, the second and third opinion physicians' reports, and any other medical reports which address the

disputed diagnostic services, diagnosis or medical treatment to the IMR. The MPN Contact shall furnish a copy of all correspondence from, and received by, any treating physician who provided a treatment or diagnostic service to the covered employee in connection to the injury. The MPN Contact shall also send a copy of the documents to the covered employee. The employee may furnish any relevant medical records to the independent medical reviewer, with a copy to the MPN contact. If an in-person examination is requested and if a special form of transportation is required because of the employee's medical condition, it is the obligation of the MPN Contact to arrange for it. The MPN Contact shall furnish transportation and arrange for an interpreter, if necessary, in advance of the in-person examination. All reasonable expenses of transportation shall be incurred by the insurer or employer pursuant to Labor Code section 4600. Except for the in-person examination itself, the independent medical reviewer shall have no ex parte contact with any party. Except for matters dealing with scheduling appointments, scheduling medical tests and obtaining medical records, all communications between the independent medical reviewer and any party shall be in writing, with copies served on all parties.

If the IMR requires further tests consistent with Labor Code section 5307.27 or, prior to the adoption of these guidelines, the ACOEM guidelines, and for all injuries not covered by the ACOEM guidelines or guidelines adopted by the Administrative Director, in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based, the IMR shall notify the MPN Contact within one working day of the appointment.

The IMR may order any diagnostic tests necessary to make his or her determination regarding medical treatment or diagnostic services for the injury or illness but shall not request the employee to submit to an unnecessary exam or procedure. If a test duplicates a test already given, the IMR shall provide justification for the duplicative test in his or her report.

If the employee fails to attend an examination with the IMR and fails to reschedule the appointment within five business days of the missed appointment, the IMR shall perform a review of the records and make a determination based on those records.

The IMR shall serve the report on the Administrative Director, the MPN Contact, the employee and the employee’s attorney, if any, within 20 days after the in-person examination or completion of the records review.

If the disputed health care service has not been provided and the IMR certifies in writing that an imminent and serious threat to the health of the injured employee exists, including, but not limited to, the potential loss of life, limb, or bodily function, or the immediate and serious deterioration of the injured employee, the report shall be expedited and rendered within three business days of the in-person examination by the IMR.

Subject to approval by the Administrative Director, reviews not covered by the above paragraph may be extended for up to three business days in extraordinary circumstances or for good cause.

Extensions for good cause shall be granted for: (1) Medical emergencies of the evaluator or the evaluator's family; (2) Death in the evaluator's family; or (3) Natural disasters or other community catastrophes that interrupt the operation of the evaluator's office operations.

Utilizing the medical treatment utilization schedule established pursuant to Labor Code section 5307.27 or, prior to the adoption of these guidelines, the ACOEM guidelines, and taking into account any reports and information provided, the IMR shall determine whether the disputed health care service is consistent with the recommended standards. For injuries not covered by the guidelines adopted by the Administrative Director, or, prior to the adoption of these guidelines, the ACOEM guidelines, the treatment rendered shall be in accordance with other evidence-based medical treatment guidelines which are generally recognized by the national medical community and scientifically based.

The independent medical reviewer shall not treat or offer to provide medical treatment for that injury or illness for which he or she has done an IMR evaluation for the employee unless a medical emergency arises during the in-person examination.

Neither the employee nor the employer nor the insurer shall have any liability for payment for the independent medical review which was not completed within the required timeframes unless the employee and the employer each waive the right to a new independent medical review and elect to accept the original evaluation.

12. Section 9768.12 Contents Of Independent Medical Review Reports

This section sets forth the required contents of an independent medical review report. Reports of independent medical reviewers shall include: the date of the in-person examination or record review; the patient's complaint(s); a listing of all information received from the parties reviewed in preparation of the report or relied upon for the formulation of the physician's opinion; the patient's medical history relevant to the treatment or diagnosis determination; findings on record review or in-person examination; the IMR's diagnosis; the physician's opinion whether or not the proposed treatment or diagnostic services are appropriate and indicated, if the proposed treatment or diagnostic services are not appropriate or indicated, any alternative diagnosis or treatment recommendation consistent with the utilization review guidelines shall be included; an analysis and determination whether the disputed health care service is consistent with the recommended standards set forth in ACOEM, or, if guidelines have been adopted by the Administrative Director pursuant to Labor Code section 5307.27, whether the treatment is consistent with the adopted treatment guidelines; or, for injuries not covered by ACOEM (or the guidelines adopted by the Administrative Director), whether the treatment is in accordance with other evidence-based medical treatment guidelines which are generally recognized by the national medical community and scientifically based; and the signature of the physician.

The report shall be in writing and use layperson's terms to the maximum extent possible. An independent medical reviewer shall serve with each report an executed declaration made under penalty of perjury.

13. Section 9768.13 Destruction of Records by the Administrative Director

This section provides that the Administrative Director may destroy any forms or documents submitted to the Administrative Director as part of the IMR process two years after the date of receipt.

14. Section 9768.14 Retention of Records by Independent Medical Reviewer

This section provides that each independent medical reviewer shall retain all comprehensive medical reports completed by the independent medical reviewer for a period of five years from the date of the IMR report.

15. Section 9768.14 Charges for Independent Medical Reviewers

This section provides that payment for the services of the independent medical reviewers shall be made by the employer or insurer. The fee shall be based on the Official Medical Fee Schedule using confirmatory consultation codes (99271 through 99275 for consultations, 99080 for reports, and 99358 for record reviews) and any other appropriate codes or modifiers. An IMR shall not accept any additional compensation from any source for his or her services as an IMR except for services provided to treat a medical emergency that arose during an in-person examination pursuant to section 9768.11(j).

16. Section 9768.16 Adoption of Decision

This section provides that the Administrative Director shall immediately adopt the determination of the independent medical reviewer and issue a written decision within 5 business days of receipt of the report. Additionally, the parties may appeal the Administrative Director's written decision by filing a petition with the Workers' Compensation Appeals Board and serving a copy on the Administrative Director, within twenty days after receipt of the decision.

17. Section 9768.17 Treatment Outside the Medical Provider Network

This section provides that if the IMR agrees with the diagnosis, diagnostic service, or medical treatment prescribed by the treating physician, the covered employee shall continue to receive medical treatment with physicians within the MPN.

If the IMR does not agree with the disputed diagnosis, diagnostic service, or medical treatment prescribed by the treating physician, the covered employee shall seek medical treatment with a physician of his or her choice either within or outside the MPN. If the employee chooses to receive medical treatment with a physician outside the MPN, the treatment is limited to the treatment recommended by the IMR or the diagnostic service recommended by the IMR.

The medical treatment shall be consistent with the recommended standards set forth in ACOEM or, if guidelines have been adopted by the Administrative Director pursuant to Labor Code section 5307.27, consistent with the adopted treatment guidelines. For injuries not covered by ACOEM (or guidelines adopted by the Administrative Director), treatment shall be consistent

with other evidence based medical treatment guidelines which are generally recognized by the national medical community and scientifically based.

The employer or insurer shall be liable for the cost of any approved medical treatment in accordance with Labor Code section 5307.1 or 5307.11.

MATTERS PRESCRIBED BY STATUTE APPLICABLE TO THE AGENCY OR TO ANY SPECIFIC REGULATION OR CLASS OF REGULATIONS

There are no other matters prescribed by statute applicable to the Division of Workers' Compensation or to any specific regulation or class of regulations.

MANDATE ON LOCAL AGENCIES OR SCHOOL DISTRICTS

None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district.

FISCAL IMPACTS

Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code:

None.

Other nondiscretionary costs/savings imposed upon local agencies:

None. The establishment of a medical provider network plan is discretionary.

Costs or savings to state agencies or costs/savings in federal funding to the State:

Labor Code section 4616.4 authorizes the Administrative Director to contract with physicians to perform independent medical reviews. The costs associated with this new workload to the Division of Workers' Compensation were included in the medical provider network rulemaking and therefore no additional costs are required by these regulations.